SERFF Tracking Number:	*UHLC-127123054*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare Insurance Company*	*State Tracking Number:*	*48486*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001C Any Size Group - Other*
Product Name:	*2011 Benefit Summary*		
Project Name/Number:	*/*		

Filing at a Glance

Company: UnitedHealthcare Insurance Company

Product Name: 2011 Benefit Summary	SERFF Tr Num: UHLC-127123054	State: Arkansas
TOI: H16G Group Health - Major Medical	SERFF Status: Closed-Approved-Closed	State Tr Num: 48486
Sub-TOI: H16G.001C Any Size Group - Other	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Author: Ebony Terry	Disposition Date: 04/15/2011
	Date Submitted: 04/13/2011	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Authorized
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Group Market Type:	Overall Rate Impact:
Filing Status Changed: 04/15/2011	
State Status Changed: 04/15/2011	Deemer Date:
Created By: Ebony Terry	Submitted By: Ebony Terry
Corresponding Filing Tracking Number:	
PPACA: Not PPACA-Related	
PPACA Notes: null	

Filing Description:

2011 Benefit Summary

Company and Contact

Filing Contact Information

Ebony Terry, Compliance Analyst	Ebony_N_Terry@uhc.com
800 King Farm Blvd.	240-632-8053 [Phone]

SERFF Tracking Number:	*UHLC-127123054*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare Insurance Company*	*State Tracking Number:*	*48486*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001C Any Size Group - Other*
Product Name:	*2011 Benefit Summary*		
Project Name/Number:	*/*		

Suite 500
Rockville, MD 20850

Filing Company Information

UnitedHealthcare Insurance Company	CoCode: 79413	State of Domicile: Connecticut
185 Asylum Street	Group Code: 707	Company Type: Life and Health
Hartford, CT 06103	Group Name:	State ID Number:
(860) 702-5000 ext. [Phone]	FEIN Number: 36-2739571	

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
UnitedHealthcare Insurance Company	$50.00	04/13/2011	46552106

SERFF Tracking Number:	*UHLC-127123054*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare Insurance Company*	*State Tracking Number:*	*48486*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001C Any Size Group - Other*
Product Name:	*2011 Benefit Summary*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	04/15/2011	04/15/2011

SERFF Tracking Number:	*UHLC-127123054*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare Insurance Company*	*State Tracking Number:*	*48486*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001C Any Size Group - Other*
Product Name:	*2011 Benefit Summary*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 04/15/2011
Implementation Date:
Status: Approved-Closed
HHS Status: HHS Approved
State Review: Reviewed-No Actuary
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*UHLC-127123054*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare Insurance Company*	*State Tracking Number:*	*48486*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001C Any Size Group - Other*
Product Name:	*2011 Benefit Summary*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Form	Benefit Summary	Approved-Closed	Yes

SERFF Tracking Number:	*UHLC-127123054*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare Insurance Company*	*State Tracking Number:*	*48486*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001C Any Size Group - Other*
Product Name:	*2011 Benefit Summary*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 04/15/2011	BENSUM.CPON.I.09.AR	Outline of Coverage	Benefit Summary	Initial			AR Federal Legislation 2007 KA SB INS Medical PLUS _1 10 11.pdf

UnitedHealthcare®
A UnitedHealth Group Company℠

Benefit Summary

Arkansas – [[Choice Plus][Options PPO][Non-Differential PPO]]
[Plan Category Name] – [Plan Description] Plan [XX-X]

We know that when people know more about their health and health care, they can make better informed health care decisions. We want to help you understand more about your health care and the resources that are available to you.

- **myuhc.com®** - Take advantage of easy, time-saving online tools. You can check your eligibility, benefits, claims, claim payments, search for a doctor and hospital and much, much more.
- **24-hour nurse support** – A nurse is a phone call away and you have other health resources available 24-hours a day, 7 days a week to provide you with information that can help you make informed decisions. Just call the number on the back of your ID card.
- **Customer Care telephone support** – Need more help? Call a customer care professional using the toll-free number on the back of your ID card. Get answers to your benefit questions or receive help looking for a doctor or hospital.

PLAN HIGHLIGHTS

Types of Coverage	[[Network] Benefits]	[Non-Network Benefits]
[Annual Deductible] –[Combined Medical and Pharmacy]		
[Individual Deductible][Single Coverage Deductible]	[$[0-15,000] per year][No Annual Deductible]	[$[0-15,000] per year][No Annual Deductible]
[Family Deductible][Family Coverage Deductible]	[$[0-45,000] per year][No Annual Deductible]	[$[0-45,000] per year][No Annual Deductible]

- [This benefit plan contains a Per Occurrence Deductible that applies to certain Covered Health Services. This Per Occurrence Deductible must be met prior to and in addition to the Annual Deductible.]
- [Member Copayments do [not] accumulate towards the Deductible.]
- [No one in the family is eligible for Benefits until the family coverage Deductible is met.]
- [All Individual Deductible amounts will count toward the Family Deductible, but an individual will not have to pay more than the Individual Deductible amount.]

[Out-of-Pocket Maximum] –[Combined Medical and Pharmacy]		
[Individual Out-of-Pocket Maximum] [Single Coverage Out-of-Pocket Maximum]	[$[0-45,000] per year][No Out-of-Pocket Maximum]	[$[0-45,000] per year][No Out-of-Pocket Maximum]
[Family Out-of-Pocket Maximum] [Family Coverage Out-of-Pocket Maximum]	[$[0-135,000] per year][No Out-of-Pocket Maximum]	[$[0-135,000] per year][No Out-of-Pocket Maximum]

- [The Out-of-Pocket Maximum [includes] [does not include] [the Annual Deductible] [and] [Per Occurrence Deductible].]
- [If more than one person in a family is covered under the Policy, the [individual] [single coverage] Out-of-Pocket Maximum stated above does not apply.]
- [Member Copayments do not accumulate towards the Out-of Pocket Maximum.]
- [All Individual Out-of-Pocket Maximum amounts will count toward the Family Out-of-Pocket Maximum, but an individual will not have to pay more than the Individual Out-of-Pocket Maximum amount.]

Benefit Plan Coinsurance – The Amount We Pay		
	[[50-100]% [after Deductible has been met][Deductible does not apply]]	[[50-100]% [after Deductible has been met]

The Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Certificate of Coverage (COC), the COC shall prevail. It is recommended that you review your COC for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

PLAN HIGHLIGHTS

Types of Coverage	[[Network] Benefits]	[Non-Network Benefits]
Maximum Policy Benefit		
The maximum amount we will pay during the entire period of time you are enrolled under the Policy.	No Maximum Policy Benefit.	
[Annual Maximum Benefit]		
[The maximum amount we will pay for Benefits during the year.]	[Combined Network and Non-Network Maximum of $[2,000-500,000] per Covered Person]	
	[$[2,000-500,000] per Covered Person]	[$[2,000-500,000] per Covered Person]
[Prescription Drug Benefits]		
[Prescription drug benefits are shown under separate cover.]		

Information on Benefit Limits

- The [Annual Deductible,] [and] [Out-of-Pocket Maximum] [and] [Benefit limits] are calculated on a [Policy][calendar] year basis.
- [All Benefits are reimbursed based on Eligible Expenses. For a definition of Eligible Expenses, please refer to your Certificate of Coverage.]
- [When Benefit limits apply, the limit refers to any combination of Network and Non-Network Benefits unless specifically stated in the Benefit category.]

MOST COMMONLY USED BENEFITS

Types of Coverage	[[Network] Benefits]	[Non-Network Benefits]
Physician's Office Services – Sickness and Injury		
[Primary Physician Office Visit]	[Designated Network:[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a $[5-100] Copayment] [Network:] [[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a $[5-100] Copayment per visit] [100% after you pay a $[5-100] Copayment per visit for the first [#] visits in a year; [50-90]% for any subsequent visits in that year]	[[50-100]% [after Deductible has been met]] [100% after you pay a $[5-100] Copayment per visit] [100% after you pay a $[5-100] Copayment per visit for the first [#] visits in a year; [50-90]% for any subsequent visits in that year]
[Specialist Physician Office Visit]	[Designated Network:[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a $[5-100] Copayment] [Network:] [[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a $[5-100] Copayment per visit] [100% after you pay a $[5-100] Copayment per visit for the first [#] visits in a year; [50-90]% for any subsequent visits in that year]	[[50-100]% [after Deductible has been met]] [100% after you pay a $[5-100] Copayment per visit] [100% after you pay a $[5-100] Copayment per visit for the first [#] visits in a year; [50-90]% for any subsequent visits in that year]

[Primary and Specialist Physician Office Visit]	[100% after you pay a $[5-75] Copayment per visit for a Primary Physician office visit or $[5-100] Copayment per visit for a Specialist Physician office visit for the first [#] visits in a year; [50-90]% [after Deductible has been met] for any subsequent visits in that year]	[[50-100]% [after Deductible has been met]] [100% after you pay a $[5-100] Copayment per visit] [100% after you pay a $[5-100] Copayment per visit for the first [#] visits in a year; [50-90]% for any subsequent visits in that year] [100% after you pay a $[5-75] Copayment per visit for a Primary Physician office visit or $[5-100] Copayment per visit for a Specialist Physician office visit for the first [#] visits in a year; [50-90]% [after Deductible has been met] for any subsequent visits in that year]

[In addition to the office visit Copayment stated in this section, the Copayments and any Deductible/Coinsurance for the following services apply when the Covered Health Service is performed in a Physician's office:

- [Lab, radiology/X-rays and other diagnostic services described under Lab, X-Ray and Diagnostics - Outpatient.]
- [Major diagnostic and nuclear medicine described under Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.]
- [Diagnostic and therapeutic scopic procedures described under Scopic Procedures - Outpatient Diagnostic and Therapeutic.]
- [Outpatient surgery procedures described under Surgery - Outpatient.]
- [Outpatient therapeutic procedures described under Therapeutic Treatments - Outpatient.]
- [Rehabilitation therapy procedures described under Rehabilitation Services - Outpatient Therapy [and Manipulative Treatment].]]

Preventive Care Services		
Covered Health Services include but are not limited to:		
Primary Physician Office Visit	100% Deductible does not apply	[Non-Network Benefits are not available except for children under the age of 19]
Well baby and well child care includes, but not limited to, 20 visits at approximately the following age intervals: birth, two weeks, two months, four months, six months, nine months, 12 months, 15 months, 18 months, two years, three years, four years, five years, six years, eight years, 10 years, 12 years, 14 years, 16 years, and 18 years. No Copayment, Coinsurance or deductible will be applicable to Network or non-Network children's immunizations.		[100% after you pay a $[5-100] Copayment per visit] [[50-100]% [after Deductible has been met]]
Specialist Physician Office Visit	100% Deductible does not apply	
Well baby and well child care includes, but not limited to, 20 visits at approximately the following age intervals: birth, two weeks, two months, four months, six months, nine months, 12 months, 15 months, 18 months, two years, three years, four years, five years, six years, eight years, 10 years, 12 years, 14 years, 16 years, and 18 years. No Copayment, Coinsurance or deductible will be applicable to Network or non-Network children's		

immunizations.

Lab, X-Ray or other preventive tests	100% Deductible does not apply

No deductible will be applicable to Network or non-Network Prostate Cancer Screening.

MOST COMMONLY USED BENEFITS

Types of Coverage	[[Network] Benefits]	[Non-Network Benefits]
Urgent Care Center Services		
	[[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a $[5-150] Copayment per visit] [100% for the first [#] visits in a year; [50-90]% for any subsequent visits in that year] [100% after you pay a $[5-150] Copayment per visit for the first [#] visits in a year; [50-90]% for any subsequent visits in that year]	[[50-100]% [after Deductible has been met]] [100% after you pay a $[5-150] Copayment per visit] [100% for the first [#] visits in a year; [50-90]% for any subsequent visits in that year] [100% after you pay a $[5-150] Copayment per visit for the first [#] visits in a year; [50-90]% for any subsequent visits in that year]

[In addition to the Copayment stated in this section, the Copayments and any Deductible/Coinsurance for the following services apply when the Covered Health Service is performed at an Urgent Care Center:

- [Lab, radiology/X-rays and other diagnostic services described under Lab, X-Ray and Diagnostics - Outpatient.]
- [Major diagnostic and nuclear medicine described under Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.]
- [Diagnostic and therapeutic scopic procedures described under Scopic Procedures - Outpatient Diagnostic and Therapeutic.]
- [Outpatient surgery procedures described under Surgery - Outpatient.]
- [Outpatient therapeutic procedures described under Therapeutic Treatments - Outpatient.]
- [Rehabilitation therapy procedures described under Rehabilitation Services - Outpatient Therapy [and Manipulative Treatment].]]

Emergency Health Services - Outpatient		
	[1]Include for 2-tier Copayment option *[2]Include for 3-tier Copayment option* *[3]Include for 4-tier Copayment option* [[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a $[5- 500] Copayment per visit]. [If you are admitted as an inpatient to a Network Hospital [directly from the Emergency room] [within 24 hours of receiving outpatient Emergency treatment for the same condition], you will not have to pay this Copayment. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.]] [100% for the first [#] visits in a year; [50-90]% for any subsequent visits in that year] [100% after you pay a $[5-500] Copayment per visit for the first [#] visits in a year; [50-90]% for any subsequent visits in that year] [[1]100% after you pay a $[5-500] Copayment per visit for the first [#] visits in a year; 100% after you pay a $[50-650] Copayment per visit [[1]for any subsequent visits in that year][[2]for the next [#] visits in	[[50-100]% [after Network Deductible has been met][Deductible does not apply]] [100% after you pay a $[5-300] Copayment per visit]

	a year][[2]; 100% after you pay a $[100-700] Copayment per visit for any subsequent visits in that year] [[3]100% after you pay a $[5-500] Copayment per visit for the first [#] visits in a year; 100% after you pay a $[50-650] Copayment per visit for the next [#] visits in a year; 100% after you pay a $[100-500] Copayment per visit for the next [#] visits in a year; 100% after you pay a $[150-700] Copayment per visit for any subsequent visits in that year]] *[Pre-service Notification is required if results in an Inpatient Stay.]*	*[Pre-service Notification is required if results in an Inpatient Stay.]*
Hospital – Inpatient Stay		
	[[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a $[100-1,000] Copayment per day] [100% after you pay a $[100-2,000] Copayment per Inpatient Stay] [Per Occurrence Deductible of [$[100-2,000] per Inpatient Stay][$[100-1,000] per day] and Annual Deductible have been met] [100% after you pay a $[100-1,000] Copayment per day to a maximum $[100-10,000] Copayment per Inpatient Stay] *[Pre-service Notification is required.]*	[[50-100]% [after Deductible has been met]] [100% after you pay a $[100-1,000] Copayment per day] [100% after you pay a $[100-2,000] Copayment per Inpatient Stay] [Per Occurrence Deductible of [$[100-2,000] per Inpatient Stay][$[100-1,000] per day] and Annual Deductible have been met] [100% after you pay a $[100-1,000] Copayment per day to a maximum $[100-10,000] Copayment per Inpatient Stay] *[Pre-service Notification is required.]*

ADDITIONAL CORE BENEFITS

Types of Coverage	**[[Network] Benefits]**	**[Non-Network Benefits]**
[Acupuncture Services]		
Benefits are limited as follows: [[10-100] visits per year] [[10-100] visits per year, not to exceed $[100-5,000] in Eligible Expenses per year] [$[100-5,000] in Eligible Expenses per year]]	[[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a $[5-75] Copayment per visit] [100% after you pay a $[5-100] Copayment per visit for the first [#] visits in a year; [50-90]% for any subsequent visits in that year]	[[50-100]% [after Deductible has been met]] [100% after you pay a$[5-75] Copayment per visit] [100% after you pay a $[5-100] Copayment per visit for the first [#] visits in a year; [50-90]% for any subsequent visits in that year] [Non-Network Benefits are not available]
Ambulance Services – Emergency and Non-Emergency		
Ground Ambulance	[[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a $[300-1,000] Copayment per day] [100% after you pay a $[25-300] Copayment per transport]	[[50-100]% [after Network Deductible has been met][Deductible does not apply]] [100% after you pay a $[300-1,000] Copayment per day] [100% after you pay a $[25-300]

	[100% after you pay a $[300-1,000] Copayment per day, up to a per day maximum of $[300-1,000]]	Copayment per transport]
Air Ambulance	[[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a $[2,500-10,000] Copayment per day] [100% after you pay a $[25-2,500] Copayment per transport] [100% after you pay a $[2,500-10,000] Copayment per day, up to a per day maximum of $[2,500-10,000]] *[Pre-service Notification is required for Non-Emergency Ambulance.]*	[[50-100]% [after Network Deductible has been met][Deductible does not apply]] [100% after you pay a $[2,500-10,000] Copayment per day] [100% after you pay a $[25-2,500] Copayment per transport] *[Pre-service Notification is required for Non-Emergency Ambulance.]*
[Congenital Heart Disease (CHD) Surgeries]		
[Benefits are limited to $[30,000 - 250,000] per CHD surgery.]	[[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a $[100-1,000] Copayment per day] [100% after you pay a $[100-2,000] Copayment per Inpatient Stay] [Per Occurrence Deductible of [$[100-2,000] per Inpatient Stay][$100-1,000] per day] and Annual Deductible have been met] [100% after you pay a $[100-1,000] Copayment per day to a maximum $[100-5,000] Copayment per Inpatient Stay] *[Pre-service Notification is required.]*	[[50-100]% [after Deductible has been met]] [100% after you pay a $[100-1,000] Copayment per day] [100% after you pay a $[100-2,000] Copayment per Inpatient Stay] [Per Occurrence Deductible of [$[100-2,000] per Inpatient Stay][$100-1,000] per day] and Annual Deductible have been met] [100% after you pay a $[100-1,000] Copayment per day to a maximum $[100-5,000] Copayment per Inpatient Stay] [Benefits are limited to [$30,000-$250,000] per surgery] *[Pre-service Notification is required.]*
[Dental Services – Accident Only]		
[Benefits are limited as follows: $[2,000-5,000] maximum per year $[500-1,500] maximum per tooth]	[[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a $[5-75] Copayment per visit] *[Pre-service Notification is required.]*	[[50-100]% [after Network Deductible has been met][Deductible does not apply]][100% after you pay a $[5-75] Copayment per visit] *[Pre-service Notification is required.]*

ADDITIONAL CORE BENEFITS

Types of Coverage	[[Network] Benefits]	[Non-Network Benefits]
Diabetes Services		
Diabetes Self Management and Training Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
Diabetes Self Management Items Benefits for diabetes equipment that meets the definition of Durable Medical Equipment are subject to the limit stated under Durable Medical Equipment.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under Durable Medical Equipment and in the Outpatient Prescription Drug Rider.	
	[Pre-service Notification is required for Durable Medical Equipment and Diabetes Equipment in excess of $[1,000-5,000].]	*[Pre-service Notification is required for Durable Medical Equipment and Diabetes Equipment in excess of $[1,000-5,000].]*
[Durable Medical Equipment]		

[Benefits are limited as follows: $[500-100,000] per year and are limited to a single purchase of a type of Durable Medical Equipment (including repair and replacement) every [year] [two-five] years.] [Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Policy. Benefits for repair/replacement are limited to once every three years. Speech aid and tracheo-esophageal voice devices are [not] included in the annual limits stated above.]	[[50-100]% [after Deductible has been met][Deductible does not apply]] *[Pre-service Notification is required for Durable Medical Equipment in excess of $[1,000-5,000].]*	[[50-100]% [after Deductible has been met]] *[Pre-service Notification is required for Durable Medical Equipment in excess of $[1,000-5,000].]*

This benefit category contains services/devices that may be Essential or non-Essential Health Benefits as defined by the Patient Protection and Affordable Care Act depending upon the service or device delivered. A benefit review will take place once the dollar limit is exceeded. If the service/device is determined to be rehabilitative or habilitative in nature, it is an Essential Health Benefit and will be paid. If the benefit/device is determined to be non-essential, the maximum will have been met and the claim will not be paid.

Hearing Aids		
[Benefits are limited as follows: [Limited to $[2,800 – 5,000] in Eligible Expenses per year. Benefits are limited to a single purchase (including repair/replacement) every [year][[three-five] years].] [No Copayment, Coinsurance or Deductible will be applicable to Network or non-Network Hearing Aid Coverage.]	[[50-100]% [after Deductible has been met][Deductible does not apply]]	[[50-100]% [after Deductible has been met]]
Home Health Care		
[Benefits are limited as follows: [[40-200] visits per year] [$[500-5,000 per year] [[40-200] visits per year to a maximum of $[500-5,000] in Eligible Expenses per year.] [[40-200] visits per year for Network Benefits and [40-200] visits per year for Non-Network Benefits. One visit equals up to four hours of skilled care services.]]	[[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a $[5-50] Copayment per visit] *[Pre-service Notification is required.]*	[[50-100]% [after Deductible has been met]] [100% after you pay a $[5-50] Copayment per visit] *[Pre-service Notification is required.]*

ADDITIONAL CORE BENEFITS

Types of Coverage	**[[Network] Benefits]**	**[Non-Network Benefits]**
Hospice Care		
	[[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a $[5-100]	[[50-100]% [after Deductible has been met]] [100% after you pay a $[5-100]

	Copayment per day] *[Pre-service Notification is required for Inpatient stays.]*	Copayment per day] *[Pre-service Notification is required for Inpatient stays.]*
[Infertility Services]		
[Benefits are limited as follows: $[2,000-30,000] per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy. [This limit includes Benefits for infertility medications provided under the Outpatient Prescription Drug Rider.] [This limit does not include Physician office visits for the treatment of infertility for which Benefits are described under Physician's Office Services – Sickness and Injury.]	[[50-100]% [after Deductible has been met][Deductible does not apply]] *[Pre-service Notification is required.]*	[[50-100]% [after Deductible has been met]] [Non-Network Benefits are not available.] *[Pre-service Notification is required.]*
Lab, X-Ray and Diagnostics - Outpatient		
For Preventive Lab, X-Ray and Diagnostics, refer to the Preventive Care Services category.	[[50-100]% [after Deductible has been met][Deductible does not apply]]	[[50-100]% [after Deductible has been met]]
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient		
	[[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a $[25-500] Copayment per service]	[[50-100]% [after Deductible has been met]] [100% after you pay a $[25-500] Copayment per service]
[Obesity Surgery]		
[Benefits are limited as follows: $[50,000-250,000] per Covered Person during the entire period of time a Covered Person is enrolled for coverage under the Policy.]	Depending upon where the Covered Health Service is provided Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. *[Pre-service Notification is required.]*	*Pre-service Notification is required.]* [Benefits are limited to $[25,000-30,000]
[Ostomy Supplies]		
[Benefits are limited as follows: $[500-25,000] per year.]	[[50-100]% [after Deductible has been met][Deductible does not apply]]	[[50-100]% [after Deductible has been met]
Pharmaceutical Products - Outpatient		
This includes medications administered in an outpatient setting, in the Physician's Office and by a Home Health Agency.	[[50-100]% [after Deductible has been met][Deductible does not apply]]	[[50-100]% [after Deductible has been met]]

ADDITIONAL CORE BENEFITS

Types of Coverage	**[[Network] Benefits]**	**[Non-Network Benefits]**
Physician Fees for Surgical and Medical Services		
	[Designated Network: [50-100]% [after Deductible has been met][Deductible does not apply]] [Network:] [[50-100]% [after Deductible has been met][Deductible does not apply]]	[[50-100]% [after Deductible has been met]
Pregnancy – [Maternity Services] [Complications of Pregnancy only]		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each covered Health Service category in this Benefit Summary.	

	[For services provided in the Physician's Office, a Copayment will only apply to the initial office visit.] *[Pre-service Notification is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.]*	*[Pre-service Notification is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.]*
Prosthetic Devices and Services		
Benefits for replacement are limited to a single purchase of each type of prosthetic device every three years.	[[50-100]% [after Deductible has been met][Deductible does not apply]]	[[50-100]% [after Deductible has been met]]
This benefit category contains services/devices that may be Essential or non-Essential Health Benefits as defined by the Patient Protection and Affordable Care Act depending upon the service or device delivered. A benefit review will take place once the dollar limit is exceeded. If the service/device is determined to be rehabilitative or habilitative in nature, it is an Essential Health Benefit and will be paid. If the benefit/device is determined to be non-essential, the maximum will have been met and the claim will not be paid.		
Reconstructive Procedures		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. *[Pre-service Notification is required.]*	*[Pre-service Notification is required.]*

ADDITIONAL CORE BENEFITS

Types of Coverage	**[[Network] Benefits]**	**[Non-Network Benefits]**
Rehabilitation Services – Outpatient Therapy [and Manipulative Treatment]		
[Benefits are limited as follows: [10-100] visits of physical therapy [10-100] visits of occupational therapy [[10-100] visits of Manipulative Treatment] [10 -100] visits of speech therapy [10-100] visits of pulmonary rehabilitation [10-100] visits of cardiac rehabilitation [10-100] visits of post-cochlear implant aural therapy] [[10-100] visits of vision therapy]] [Any combination of physical therapy, occupational therapy, [Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, [and vision therapy] is limited to [10- 160] visits per year.] [Any combination of physical therapy, occupational therapy, [Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, [and vision therapy] is limited to $[750- 12,000] per year.] [Network Benefits for any combination of physical therapy, occupational	[[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a $[5-75] Copayment per visit] [100% after you pay a $[5-100] Copayment per visit for the first [#] visits in a year; [50-90]% for any subsequent visits in that year]	[[50-100]% [after Deductible has been met]] [100% after you pay a $[5-75] Copayment per visit] [100% after you pay a $[5-100] Copayment per visit for the first [#] visits in a year; [50-90]% for any subsequent visits in that year]

therapy, [Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, [and vision therapy] are limited to [10-160] visits per year. Non-Network Benefits for any combination of physical therapy, occupational therapy, [Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, [and vision therapy] are limited to [10-160] visits per year.]		
	[Pre-service Notification is required for certain services.]	*[Pre-service Notification is required for certain services.]*
Scopic Procedures – Outpatient Diagnostic and Therapeutic		
Diagnostic scopic procedures include, but are not limited to: Colonoscopy Sigmoidoscopy Endoscopy For Preventive Scopic Procedures, refer to the Preventive Care Services category.	[[50-100]% [after Deductible has been met][Deductible does not apply]]	[[50-100]% [after Deductible has been met]]

ADDITIONAL CORE BENEFITS

Types of Coverage	**[[Network] Benefits]**	**[Non-Network Benefits]**
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
[Benefits are limited as follows: [[40-180] days per year] [[40-180] days per year for Network Benefits] [40-180 days per year for Non-Network Benefits]]	[[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a $[50-1,000] Copayment per day] [100% after you pay a $[50-2,000] Copayment per Inpatient Stay] [If you are transferred to a Skilled Nursing Facility or Inpatient Rehabilitation Facility directly from an acute facility, any combination of Copayments required for the Inpatient Stay in a Hospital and the Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility will apply to the stated maximum Copayment per Inpatient Stay.][No Copayment applies if you are transferred to a Skilled Nursing Facility or Inpatient Rehabilitation Facility directly from an acute facility.] [100% after you pay a $[50-1,000] Copayment per day to a maximum $[50-5,000] Copayment per Inpatient Stay]	[[50-100]% [after Deductible has been met]] [100% after you pay a $[50-1,000] Copayment per day] [100% after you pay a $[50-2,000] Copayment per Inpatient Stay] [100% after you pay a $[50-1,000] Copayment per day to a maximum $[50-10,000] Copayment per Inpatient Stay]
	[Pre-service Notification is required.]	*[Pre-service Notification is required.]*
Surgery - Outpatient		
	[[50-100]% [after Deductible has been met][Deductible does not apply]] [[100% after you pay a $[10 - 1,000] Copayment per date of service] [Per Occurrence Deductible of [$[10-1,000] per date of service and Annual Deductible have been met]	[[50-100]% [after Deductible has been met]] [[100% after you pay a $[10 - 1,000] Copayment per date of service] [Per Occurrence Deductible of [$[10-1,000] per date of service and Annual Deductible have been met]

Temporomandibular Joint Services		
[Benefits are limited as follows: $[1,000 - 20,000] per year.]	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. *[Pre-service Notification is required.]*	*[Pre-service Notification is required.]*
Therapeutic Treatments - Outpatient		
Therapeutic treatments include, but are not limited to: Dialysis Intravenous chemotherapy or other intravenous infusion therapy Radiation oncology	[[50-100]% [after Deductible has been met][Deductible does not apply]] *[Pre-service Notification is required for certain services]*	[[50-100]% [after Deductible has been met]] *[Pre-service Notification is required for certain services]*

ADDITIONAL CORE BENEFITS

Types of Coverage	**[[Network] Benefits]**	**[Non-Network Benefits]**
Transplantation Services		
	[[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a $[100 - 1,000] Copayment per day] [100% after you pay a $[100 - 2,000] Copayment per Inpatient Stay] [Per Occurrence Deductible of [$[100-2,000] per Inpatient Stay][$100-1,000] per day] and Annual Deductible have been met] [100% after you pay a $[100-1,000] Copayment per day to a maximum $[100-5,000] Copayment per Inpatient Stay] [For Network Benefits, services must be received at a Designated Facility.] *[Pre-service Notification is required.]*	[[50-100]% [after Deductible has been met]] [100% after you pay a $[100 - 1,000] Copayment per day] [100% after you pay a $[100 - 2,000] Copayment per Inpatient Stay] [Non-Network Benefits are not available.] [Per Occurrence Deductible of [$[100-2,000] per Inpatient Stay][$100-1,000] per day] and Annual Deductible have been met] [100% after you pay a $[100-1,000] Copayment per day to a maximum $[100-5,000] Copayment per Inpatient Stay] [Benefits are limited to $[30,000-250,000] per Transplant.] *[Pre-service Notification is required.]*
[Vision Examinations]		
[Benefits are limited as follows: [1 exam] [[2-3] exams] [every [2-3] years] [per year]]	[[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a [$5 - 75] Copayment per visit]	[Non-Network Benefits are not available] [100% after you pay a [$5 - 75] Copayment per visit] [[50-100]% [after Deductible has been met]]
[Wigs]		
[Benefits are limited as follows: [$[100 - 1,000] per year.] [$[100 - 5,000] every [24 - 36] months].]]	[[50-100]% [after Deductible has been met][Deductible does not apply]]	[[50-100]% [after Deductible has been met]]

STATE MANDATED BENEFITS

Types of Coverage	[[Network] Benefits]	[Non-Network Benefits]
[Clinical Trials]		
[Participation in a qualifying clinical trial for the treatment of: Cancer Cardiovascular (cardiac/stroke) Surgical musculoskeletal disorders of the spine, hip and knees]	[Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.]	
	[Pre-service Notification is required.]	*[Pre-service Notification is required.]*
Dental Services - Anesthesia and Hospitalization		
	Benefits will be the same as those stated under Hospital - Inpatient Stay in this Benefits Summary.	
	[Pre-service Notification is required.]	*[Pre-service Notification is required.]*
In Vitro Fertilization Services		
Benefits are limited as follows: $15,000 lifetime maximum.	[[50 - 100]%]	[[50 - 100]%] [Non-Network Benefits are not available.]
	[Pre-service Notification is required.]	*[Pre-service Notification is required.]*
Medical Foods		
	Depending upon where the Covered Health Service is provided, Benefits will be [50 - 100] % [or as provided under the Outpatient Prescription Drug Rider].	Same as Network
Mental Health Services		
[[For groups with 50 or less total employees:] [Benefits are limited as follows: [[10-100] days per year for Inpatient Mental Health Services] [[10-100] visits per year for Outpatient Mental Health Services] [[10-100] days per year for Non-Network Benefits for Inpatient Mental Health Services] [[10-100] visits per year for Non-Network Benefits for Outpatient Mental Health Services]]	[For groups with 50 or less total employees:] [Inpatient] [[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a $[100 - 1,000] Copayment per day] [100% after you pay a $[100 - 2,000] Copayment per Inpatient Stay] [100% after you pay a $[100 - 1,000] Copayment per day to a maximum $[100 - 5,000] Copayment per Inpatient Stay]	[For groups with 50 or less total employees:] [Inpatient] [[50-100]% [after Deductible has been met]] [100% after you pay a $[100 - 1,000] Copayment per day] [100% after you pay a $[100 - 2,000] Copayment per Inpatient Stay] [100% after you pay a $[100 - 1,000] Copayment per day to a maximum $[100 - 5,000] Copayment per Inpatient Stay]
[Benefits for any combination of Mental Health Services and Neurobiological Disorders – Autism Spectrum Disorders are limited as follows: [10-100] days per year for	[Outpatient] [[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a $[5 - 100] Copayment per visit]	[Outpatient] [[50-100]% [after Deductible has been met]] [100% after you pay a $[5 - 100]

Inpatient Mental Health Services and Neurobiological Disorders – Autism Spectrum Disorders [10-100] visits per year for Outpatient Mental Health Services and Neurobiological Disorders – Autism Spectrum Disorders] [Benefits for any combination of Mental Health Services and Substance Use Disorder Services are limited as follows: [10-100] days per year for Inpatient Mental Health Services and Substance Use Disorder Services [10-100] visits per year for Outpatient Mental Health Services and Substance Use Disorder Services]]	[100% after you pay a $[5 - 75] Copayment per individual visit; $[5 - 75] Copayment per group visit] [100% for visits for medication management]	Copayment per visit] [100% after you pay a $[5 - 75] Copayment per individual visit; $[5 - 75] Copayment per group visit] [100% for visits for medication management]
	[Pre-service Notification is required from the Mental Health/Substance Use Disorder Designee.]	*[Pre-service Notification is required from the Mental Health/Substance Use Disorder Designee.]*
Mental Health Services		
[For groups with 51 or more total employees: Benefit limits do not apply.]	[For groups with 51 or more total employees:] [Inpatient] [[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a $[100 - 1,000] Copayment per day] [100% after you pay a $[100 - 2,000] Copayment per Inpatient Stay] [100% after you pay a $[100 - 1,000] Copayment per day to a maximum $[100 - 5,000] Copayment per Inpatient Stay] [Outpatient] [[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a $[5 - 100] Copayment per visit] [100% after you pay a $[5 - 75] Copayment per individual visit; $[5 - 75] Copayment per group visit] [100% for visits for medication management]	[For groups with 51 or more total employees:] [Inpatient] [[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a $[100 - 1,000] Copayment per day] [100% after you pay a $[100 - 2,000] Copayment per Inpatient Stay] [100% after you pay a $[100 - 1,000] Copayment per day to a maximum $[100 - 5,000] Copayment per Inpatient Stay] [Outpatient] [[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a $[5 - 100] Copayment per visit] [100% after you pay a $[5 - 75] Copayment per individual visit; $[5 - 75] Copayment per group visit] [100% for visits for medication management]
	[Pre-service Notification is required from the Mental Health/Substance Use Disorder Designee.]	*[Pre-service Notification is required from the Mental Health/Substance Use Disorder Designee.]*
[Musculoskeletal Disorders of the Face, Neck or Head]		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.

	[Pre-service Notification is required.]	*[Pre-service Notification is required.]*
[Neurobiological Disorders – Autism Spectrum Disorder Services]		
[For groups with 50 or less total employees:] [Benefits are limited as follows: [[10-100] days per year for Inpatient Neurobiological Disorders – Autism Spectrum Disorders] [[10-100] visits per year for Outpatient Neurobiological Disorders – Autism Spectrum Disorders] [[10-100] days per year for Non-Network Benefits for Inpatient Neurobiological Disorders – Autism Spectrum Disorders] [[10-100] visits per year for Non-Network Benefits for Outpatient Neurobiological Disorders – Autism Spectrum Disorders]] [Benefits for any combination of Neurobiological Disorders – Autism Spectrum Disorders and Mental Health Services are limited as follows: [10-100] days per year for Inpatient Neurobiological Disorders – Autism Spectrum Disorders and Mental Health Services [10-100] visits per year for Outpatient Neurobiological Disorders – Autism Spectrum Disorders and Mental Health Services]	[For groups with 50 or less total employees:] [Inpatient] [[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a $[100 - 1,000] Copayment per day] [100% after you pay a $[100 - 2,000] Copayment per Inpatient Stay] [100% after you pay a $[100 - 1,000] Copayment per day to a maximum $[100 - 5,000] Copayment per Inpatient Stay] [Outpatient] [[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a $[5 –100] Copayment per visit] [100% after you pay a $[5 - 75] Copayment per individual visit; $[5 - 75] Copayment per group visit] [100% for visits for medication management]	[For groups with 50 or less total employees:] [Inpatient] [[50-100]% [after Deductible has been met]] [100% after you pay a $[100 - 1,000] Copayment per day] [100% after you pay a $[100 - 2,000] Copayment per Inpatient Stay] [100% after you pay a $[100 - 1,000] Copayment per day to a maximum $[100 - 5,000] Copayment per Inpatient Stay] [Outpatient] [[50-100]% [after Deductible has been met]] [100% after you pay a $[5 –100] Copayment per visit] [100% after you pay a $[5 - 75] Copayment per individual visit; $[5 - 75] Copayment per group visit] [100% for visits for medication management]
	[Pre-service Notification is required from the Mental Health/Substance Use Disorder Designee.]	*[Pre-service Notification is required from the Mental Health/Substance Use Disorder Designee.]*
[Neurobiological Disorders – Autism Spectrum Disorder Services]		
[For groups with 51 or more total employees: Benefit limits do not apply.]	[For groups with 51 or more total employees:] [Inpatient] [[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a $[100 - 1,000] Copayment per day] [100% after you pay a $[100 - 2,000] Copayment per Inpatient Stay] [100% after you pay a $[100 - 1,000] Copayment per day to a maximum $[100 - 5,000] Copayment per Inpatient Stay] [Outpatient] [[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a $[5 - 100] Copayment per visit]	[For groups with 51 or more total employees:] [Inpatient] [[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a $[100 - 1,000] Copayment per day] [100% after you pay a $[100 - 2,000] Copayment per Inpatient Stay] [100% after you pay a $[100 - 1,000] Copayment per day to a maximum $[100 - 5,000] Copayment per Inpatient Stay] [Outpatient] [[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a $[5 - 100]

	[100% after you pay a $[5 - 75] Copayment per individual visit; $[5 - 75] Copayment per group visit] [100% for visits for medication management] *[Pre-service Notification is required from the Mental Health/Substance Use Disorder Designee.]*	Copayment per visit] [100% after you pay a $[5 - 75] Copayment per individual visit; $[5 - 75] Copayment per group visit] [100% for visits for medication management] *[Pre-service Notification is required from the Mental Health/Substance Use Disorder Designee.]*
Orthotic Devices and Services		
Benefits for replacement are limited to a single purchase of each type of orthotic device every three years.	[[50-100]% *[Pre-service Notification is required.]*	[[50-100]% *[Pre-service Notification is required.]*
Substance Use Disorder Services		
[For groups with 50 or less total employees:] [Benefits are limited as follows: [[10-100] days per year for Inpatient Substance Use Disorder Services] [[10-100] visits per year for Outpatient Substance Use Disorder Services] [[10-100] days per year for Non-Network Benefits for Inpatient Substance Use Disorder Services] [[10-100] visits per year for Non-Network Benefits for Outpatient Substance Use Disorder Services] [Benefits for any combination of Substance Use Disorder Services and Mental Health Services are limited as follows: [10-100] days per year for Inpatient Mental Health Services and Substance Use Disorder Services [10-100] visits per year for Outpatient Mental Health Services and Substance Use Disorder Services]	[For groups with 50 or less total employees:] [Inpatient] [[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a $[100 - 1,000] Copayment per day] [100% after you pay a $[100 - 2,000] Copayment per Inpatient Stay] [100% after you pay a $[100 - 1,000] Copayment per day to a maximum $[100 - 5,000] Copayment per Inpatient Stay] [Outpatient] [[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a $[5 –100] Copayment per visit] [100% after you pay a $[5 - 75] Copayment per individual visit; $[5 - 75] Copayment per group visit] [100% for visits for medication management] *[Pre-service Notification is required from the Mental Health/Substance Use Disorder Designee.]*	[For groups with 50 or less total employees:] [Inpatient] [[50-100]% [after Deductible has been met]] [100% after you pay a $[100 - 1,000] Copayment per day] [100% after you pay a $[100 - 2,000] Copayment per Inpatient Stay] [100% after you pay a $[100 - 1,000] Copayment per day to a maximum $[100 - 5,000] Copayment per Inpatient Stay] [Outpatient] [[50-100]% [after Deductible has been met]] [100% after you pay a $[5 –100] Copayment per visit] [100% after you pay a $[5 - 75] Copayment per individual visit; $[5 - 75] Copayment per group visit] [100% for visits for medication management] *[Pre-service Notification is required from the Mental Health/Substance Use Disorder Designee.]*
Substance Use Disorder Services		
[For groups with 51 or more total employees: Benefit limits do not apply.]	[For groups with 51 or more total employees:] [Inpatient] [[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a $[100 - 1,000] Copayment per day] [100% after you pay a $[100 - 2,000]	[For groups with 51 or more total employees:] [Inpatient] [[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a $[100 - 1,000] Copayment per day] [100% after you pay a $[100 - 2,000]

	Copayment per Inpatient Stay] [100% after you pay a $[100 - 1,000] Copayment per day to a maximum $[100 - 5,000] Copayment per Inpatient Stay] [Outpatient] [[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a $[5 - 100] Copayment per visit] [100% after you pay a $[5 - 75] Copayment per individual visit; $[5 - 75] Copayment per group visit] [100% for visits for medication management] *[Pre-service Notification is required from the Mental Health/Substance Use Disorder Designee.]*	Copayment per Inpatient Stay] [100% after you pay a $[100 - 1,000] Copayment per day to a maximum $[100 - 5,000] Copayment per Inpatient Stay] [Outpatient] [[50-100]% [after Deductible has been met][Deductible does not apply]] [100% after you pay a $[5 - 100] Copayment per visit] [100% after you pay a $[5 - 75] Copayment per individual visit; $[5 - 75] Copayment per group visit] [100% for visits for medication management] *[Pre-service Notification is required from the Mental Health/Substance Use Disorder Designee.]*

This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Certificate of Coverage (COC), the COC shall prevail. It is recommended that you review your COC for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

MEDICAL EXCLUSIONS

It is recommended that you review your COC for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

Alternative Treatments

Acupressure; [acupuncture]; aromatherapy; hypnotism; massage therapy; rolfing; art therapy, music therapy, dance therapy, horseback therapy; and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to [Manipulative Treatment and] non-manipulative osteopathic care for which Benefits are provided as described in Section 1 of the COC.

Dental

Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia). [This exclusion does not apply to [accident-related dental services for which Benefits are provided as described under Dental Services – Accident Only or] Dental Services - Anesthesia and Hospitalization for which Benefits are provided as described in Section 1 of the COC.] This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the policy, limited to: Transplant preparation; prior to initiation of immunosuppressive drugs; the direct treatment of acute traumatic Injury, cancer or cleft palate. Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication. Endodontics, periodontal surgery and restorative treatment are excluded. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include: extraction, restoration, and replacement of teeth; medical or surgical treatment of dental conditions; and services to improve dental clinical outcomes. This exclusion does not apply to [accidental-related dental services for which Benefits are provided as described under Dental Services – Accidental Only or] Dental Services – Anesthesia and Hospitalization for which Benefits are provided as described in Section 1 of the COC. Dental implants, bone grafts and other implant-related procedures. [This exclusion does not apply to [accident-related dental services for which Benefits are provided as described under Dental Services – Accident Only or] Dental Services - Anesthesia and Hospitalization for which Benefits are provided as described in Section 1 of the COC.] Dental braces (orthodontics). Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly.

Devices, Appliances and Prosthetics

Devices used specifically as safety items or to affect performance in sports-related activities Orthotic appliances that straighten or re-shape a body part. This exclusion does not apply to orthotics as described under Durable Medical Equipment in Section 1 of the COC. The following items are excluded, even if prescribed by a Physician: blood pressure cuff/monitor; enuresis alarm; non-wearable external defibrillator; trusses; and ultrasonic nebulizers. Devices and computers to assist in communication and speech except for speech generating devices and tracheo-esophogeal voice devices for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC. Oral appliances for snoring. [Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.] [Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.] [Prosthetic devices. This exclusion does not apply to breast prosthesis, mastectomy bras and lymphedema stockings for which Benefits are provided as described under Reconstructive Procedures in Section 1 of the COC.]

Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office. Over-the-counter drugs and treatments. Growth hormone therapy.

Experimental, Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.[This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 1 of the COC.]

Foot Care

Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in Section 1 of the COC. Nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care. Examples include: cleaning and soaking the feet; applying skin creams in order to maintain skin tone. This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes. Treatment of flat feet or subluxation of the foot. Shoes; shoe orthotics; shoe inserts and arch supports.

MEDICAL EXCLUSIONS CONTINUED

Medical Supplies [and Equipment]

Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: elastic stockings, ace bandages, gauze and dressings, urinary catheters [ostomy supplies]. This exclusion does not apply to:

- [Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC.]
- Diabetic supplies for which Benefits are provided as described under Diabetes Services in Section 1 of the COC.
- [Ostomy supplies for which Benefits are provided as described under Ostomy Supplies in Section 1 of the COC.]

Tubing and masks, [except when used with Durable Medical Equipment as described under Durable Medical Equipment as described in Section 1 of the COC.] [Medical equipment of any kind. This exclusion does not apply to insulin pumps for which Benefits are provided as described under Diabetes Services in Section 1 of the COC.]

Mental Health

[Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.] [Mental Health Services as treatments for V-code conditions as listed within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.] [Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis.] [Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias.] [Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.] [Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act.] [Learning, motor skills and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.] [Mental retardation and autism spectrum disorder as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Benefits for autism spectrum disorder as a primary diagnosis are described under Neurobiological Disorders-Autism Spectrum Disorder Services in Section 1 of the COC.] [Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:

- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
- Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
- Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.
- Not clinically appropriate for the patient's Mental Illness or condition based on generally accepted standards of medical practice and benchmarks.]

[Services for the treatment of mental illness or mental health conditions [that the Enrolling Group has elected to provide through a separate benefit plan].]

Neurobiological Disorders – Autism Spectrum Disorders

[Services as treatments of sexual dysfunction and feeding disorders as listed in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.] [Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.] [Mental retardation as the primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.] [Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act.] [Learning, motor skills and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association and which are not a part of Autism Spectrum Disorder.] [Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, and paraphilias.] [Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorder.] [Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:

- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
- Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
- Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.
- Not clinically appropriate for the patient's Mental Illness or condition based on generally accepted standards of medical practice and benchmarks.

[Services for the treatment of autism spectrum disorders as the primary diagnosis [that the Enrolling Group has elected to provide through a separate benefit plan]. (Autism spectrum disorders are a group of neurobiological disorders that includes Autistic Disorder, Rhett's Syndrome, Asperger's Disorder, Childhood Disintegrated Disorder and Pervasive Development Disorders Not Otherwise Specified (PDDNOS).)]

Nutrition

Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:

- Nutritional education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Enteral feedings, even if the sole source of nutrition. This exclusion does not apply to medical foods for which Benefits are provided as described in Section 1 of the COC. Infant formula and donor breast milk. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods).

Personal Care, Comfort or Convenience

Television; telephone; beauty/barber service; guest service. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include: air conditioners, air purifiers and filters, dehumidifiers; batteries and battery chargers; breast pumps; car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; electric scooters; exercise equipment; home modifications such as elevators, handrails and ramps; hot tubs; humidifiers; Jacuzzis; mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; stair lifts and stair glides; strollers; safety equipment; treadmills; vehicle modifications such as van lifts; video players, whirlpools.

MEDICAL EXCLUSIONS CONTINUED

Physical Appearance

Cosmetic Procedures. See the definition in Section 9 of the COC. Examples include: pharmacological regimens, nutritional procedures or treatments. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). Skin abrasion procedures performed as a treatment for acne. Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. Treatment for skin wrinkles or any treatment to improve the appearance of the skin. Treatment for spider veins. Hair removal or replacement by any means. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See Reconstructive Procedures in Section 1 of the COC. Treatment of benign gynecomastia (abnormal breast enlargement in males). Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation. [Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.] [Wigs regardless of the reason for the hair loss.]

Procedures and Treatments

Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty. Medical and surgical treatment of excessive sweating (hyperhidrosis). Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. [Rehabilitative services [and Manipulative Treatment] to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including but not limited to routine, long-term or maintenance/preventive treatment.] [Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or [autism spectrum disorders][Autism Spectrum Disorders].] [Outpatient rehabilitation services. Examples include physical therapy, speech therapy, occupational therapy, cardiac rehabilitation therapy, pulmonary rehabilitation therapy, manipulative treatment, post-cochlear implant aural therapy and vision therapy.] Psychosurgery. Sex transformation operations. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter. Biofeedback. [Manipulative treatment (the therapeutic application of chiropractic and osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function).] [The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; dental restorations.] Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury, dislocation, tumors or cancer. Orthognathic surgery[,] [and] jaw alignment, except as a treatment of obstructive sleep apnea. [This exclusion does not apply to Musculoskeletal Disorders of the Face, Neck or Head for which Benefits are provided as described in Section 1 of the COC.] [[Surgical and non-surgical treatment of obesity] [Non-surgical treatment of obesity] [Surgical treatment of obesity.] [Stand-alone multi-disciplinary smoking cessation programs.] [Breast reduction except as coverage is required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 1 of the COC.] [Breast reduction surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reduction surgery which we determine is requested to treat a physiologic functional impairment or to coverage required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 1 of the COC.]

Providers

Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services performed by a provider with your same legal residence. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider has not been actively involved in your medical care prior to ordering the service, or is not actively involved in your medical care after the service is received. This exclusion does not apply to mammography.

MEDICAL EXCLUSIONS CONTINUED

Reproduction

[Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment, except for In Vitro Fertilization Services for which Benefits are provided as described in Section 1 of the COC. This exclusion does not apply to services required to treat or correct underlying causes of infertility.] [The following infertility treatment-related services: cryo-preservation and other forms of preservation of reproductive materials, long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue, and testicular tissue, donor services.] Surrogate parenting, donor eggs, donor sperm and host uterus, [Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.] The reversal of voluntary sterilization [and voluntary sterilization]. [Health services and associated expenses for surgical, non-surgical, or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage).] [Contraceptive supplies and services.] [Fetal reduction surgery.] [Maternity related medical services for prenatal care, postnatal care and delivery (other than a non-elective cesarean delivery).] [Maternity related medical services for Enrolled Dependent children.]

Services Provided under Another Plan

[Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation. If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness, or [Mental Illness] [mental illness] that would have been covered under workers' compensation or similar legislation had that coverage been elected.] [Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, no-fault auto insurance, or similar legislation. This exclusion does not apply to Enrolling Groups that are not required by law to purchase or provide, through other arrangements, workers' compensation insurance for employees, owners and/or partners.] Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

Substance Use Disorders

[Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.] [Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.] [Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.] [Services or supplies for the diagnosis or treatment of alcoholism or substance use disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:

- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
- Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
- Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.
- Not clinically appropriate for the patient's substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.

[Services for the treatment of substance use disorder services [that the Enrolling Group has elected to provide through a separate benefit plan].

Transplants

Health services for organ and tissue transplants, except those described under Transplantation Services in Section 1 of the COC. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.) Health services for transplants involving permanent mechanical or animal organs. [Transplant services that are not performed at a Designated Facility. This exclusion does not apply to cornea transplants.]

MEDICAL EXCLUSIONS CONTINUED

Travel

Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at our discretion.

Types of Care

Multi-disciplinary pain management programs provided on an inpatient basis. Custodial care or maintenance care; domiciliary care. Private Duty Nursing. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are described under Hospice Care in Section 1 of the COC. Rest cures; services of personal care attendants. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

Purchase cost and fitting charge for eye glasses and contact lenses. [Routine vision examinations, including refractive examinations to determine the need for vision correction.] Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). [Eye exercise or vision therapy.] Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery.
Bone anchored hearing aids except when either of the following applies: for Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid, for Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled under the Policy. Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions.

All Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service – see the definition in Section 9 of the COC. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when: required solely for purposes of school, sports or camp, [travel], [career or employment,] insurance, marriage or adoption; related to judicial or administrative proceedings or orders; conducted for purposes of medical research; required to obtain or maintain a license of any type. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians Injured or otherwise affected by war, any act of war, or terrorism in non-war zones. Health services received after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy. In the event a non-Network provider waives Copayments, Coinsurance and/or any deductible for a particular health service, no Benefits are provided for the health service for which the Copayments, Coinsurance and/or deductible are waived. Charges in excess of Eligible Expenses or in excess of any specified limitation. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products. Autopsy. Foreign language and sign language services.

MEDICAL EXCLUSIONS CONTINUED

[Preexisting Conditions (Applies only to groups of 50 or less employees)]

[Benefits for the treatment of a Preexisting Condition are excluded until the date you have had Continuous Creditable Coverage for 12 months. This exclusion does not apply to Covered Persons under age 19.]

[Benefits for the treatment of a Preexisting Condition are excluded until the earlier of the following: The date you have had Continuous Creditable Coverage for 12 months; or the date you have had Continuous Creditable Coverage for 18 months if you are a Late Enrollee. This exclusion does not apply to Covered Persons under age 19.]

[Benefits for the treatment of a Preexisting Condition are excluded for Late Enrollees until the date you have had Continuous Creditable Coverage for [12] [18] months. This exclusion does not apply to Covered Persons under age 19.]

UnitedHealthcare Insurance Company

SERFF Tracking Number:	*UHLC-127123054*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare Insurance Company*	*State Tracking Number:*	*48486*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001C Any Size Group - Other*
Product Name:	*2011 Benefit Summary*		
Project Name/Number:	*/*		

Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	04/15/2011
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	04/15/2011
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	04/15/2011
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	Cover Letter	Approved-Closed	04/15/2011
Comments:			
Attachment:			

Cover INS 4.11.11.pdf

April 11, 2011,

Via U.S. Mail

Rosalyn Minor
Arkansas Insurance Department
1200 West 3rd Street
Little Rock, Arkansas 72201

NAIC: 79413 United Healthcare Insurance Company

Form # BENSUM.CPON.I.09.AR

Dear Ms. Minor,

On behalf of United Healthcare Insurance Company, please accept this correspondence as a submission of the above referenced Benefit Summary for the Arkansas Insurance Department's ("the Department") review.

This submission has been submitted electronically via SERFF and United Healthcare Insurance Company recognizes that we may not implement this form until and unless approval has been granted. Should the Department have any immediate concerns or questions regarding this submission, please feel free to contact me at 240.632.8056, through the SERFF messaging system or at Ebony_N_Terry@uhc.com.

Respectfully,

Ebony N. Terry
Compliance Analyst
Enclosure
ENT